**United States Department of State**

***Washington, D.C. 20520***

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

**INFORMATION MEMO FOR AMBASSADOR CLOUD, Botswana**

**SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction**

Dear Ambassador Cloud:

With input from the field teams through the quarterly POARTs and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern.

Responding to the directive to "reboot" mid-COP 2018, PEPFAR Botswana has since made impressive progress. We applaud the Government of Botswana (GOB) and PEPFAR Botswana working together to achieve the rapid adoption of all 2019 minimum program requirements including that of providing free antiretroviral therapy (ART) to non-citizens. The "reboot," aimed at addressing the lack of recent progress, systemic underperformance, and uneven policy adoption was a difficult transition. Both the GOB and PEPFAR Botswana faced the challenges head on and together the result is that numerous structural barriers that had been impeding efficient case-finding, immediate treatment access, and viral load monitoring for years have been eliminated. Well done. This progress on the policy front was combined with a de-emphasis of active case finding and a renewed focus on establishing durable improvements across the treatment cascade through same-day treatment initiation, client retention, viral load testing, and bringing those lost to follow up back into care. Combined, these changes in the program have undoubtedly better positioned Botswana to stem their national HIV epidemic.

In addition, we are encouraged by the prospect of quality HIV surveillance data from the fifth Botswana AIDS Impact Survey (BAIS V) being available later this year. That data is essential for optimizing resources according to unmet need. To fully leverage the upcoming BAIS data, more work in COP 2019 and beyond is needed to ensure that the new policies are fully implemented and operationalized so as to translate into sustained programmatic gains at the site level, district level, and ultimately nationwide.

While the COP 2018 trends on linkage, retention, and viral load testing are encouraging, and the minimum program requirements have been adopted, the evidence suggests that across the

treatment cascades men and adolescents are lagging behind and improvement in client-centered care is necessary.

Therefore, for COP 2020 and in anticipation of COP 2020 and the availability of BAIS V data, PEPFAR Botswana will need to develop the evidence base of solutions/structures that that address known gaps, such as men and adolescents, and focus on delivering sustainable client-centered quality care. HIV testing will need to be transformed into case-finding and improved facility and community collaboration will be needed to ensure effective implementation of active partner notification. Addressing the remaining gaps and attaining 95/95/95 will require implementing the new policies and capacities such as index testing and differentiated service delivery in innovative ways that keep the client front of mind and serve the diverse geographic, demographic, and economic needs of all Batswana. The team must also evaluate its current implementing partner structure and determine how to better unify and harmonize partners/performance across the HIV response in accordance with the COP 2020 guidance of a patient and family-centered approach. Finally, developing systems that will enable epidemic control will also require that a process for continuous quality improvement and community led monitoring of quality and accessibility be put into place. These, along with case management data systems, are systems consistent with assuring that clients are continuing with uninterrupted, life-long ART.

**SECTION 1: COP 2020 PLANNING LEVEL**

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year (EOFY) 2019 tool, and performance data, the total COP 2020 planning level is comprised as follows. Note – all pipeline numbers were provided and confirmed by your agency.

TABLE 1 : All COP 2020 Funding by Fiscal Year

| OU Total | Bilateral | | | | Central | TOTAL |
|---|---|---|---|---|---|---|
| | **FY20** | **FY19** | **FY17** | **Unspecified** | **Unspecified** | **TOTAL** |
| Total New Funding | **$ 58,308,551** | **$ 5,000,000** | **$ -** | | | **$ 63,308,551** |
| GHP- State | $ 56,112,301 | $ 5,000,000 | $ - | | | **$ 61,112,301** |
| GHP- USAID | $ - | $ - | $ - | | | **$ -** |
| GAP | $ 2,196,250 | $ - | $ - | | | **$ 2,196,250** |
| Total Applied Pipeline | | | | **$ 5,396,449** | **$ -** | **$ 5,396,449** |
| DOD | | | | $ - | $ - | **$ -** |
| HHS/CDC | | | | $ 3,735,132 | $ - | **$ 3,735,132** |
| HHS/HRSA | | | | $ - | $ - | **$ -** |
| PC | | | | $ 531,643 | $ - | **$ 531,643** |
| State | | | | $ - | $ - | **$ -** |
| USAID | | | | $ 1,129,674 | $ - | **$ 1,129,674** |
| TOTAL FUNDING | **$ 58,308,551** | **$ 5,000,000** | **$ -** | **$ 5,396,449** | **$ -** | **$ 68,705,000** |

**SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $38,100,000 and the full Orphans and Vulnerable Children (OVC) level of $18,930,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2 : COP 2020 Earmarks by Fiscal Year

| Earmarks | COP 2020 Planning Level | | | |
|---|---|---|---|---|
| | FY20 | FY19 | FY17 | Total |
| C&T | $ 28,000,000 | $ - | $ - | **$ 28,000,000** |
| OVC | $ 11,600,000 | $ - | $ - | **$ 11,600,000** |
| GBV | $ 1,000,120 | $ - | $ - | **$ 1,000,120** |
| Water | $ 50,000 | $ - | $ - | **$ 50,000** |

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.*

TABLE 3 : All COP 2020 Initiative Controls

| | COP 20 Total |
|---|---|
| Total Funding | **$ 23,200,000** |
| VMMC | $ 1,600,000 |
| Cervical Cancer | $ 1,000,000 |
| DREAMS | $ 19,000,000 |
| HBCU Tx | $ - |
| COP 19 Performance | $ - |
| HKID Requirement | $ 1,600,000 |

**SECTION 3: PAST PERFORMANCE – COP 2018 Review**

**Table 4. OU Level COP 2018 | FY 2019 Program Results and COP 2019 | FY 2020 Targets**

| Indicator | FY 2019 (COP 2018) results | FY 2020 (COP 2019) targets |
|---|---|---|
| **TX Current Adults*** | **154,412** | **170,156** |
| **TX Current Children*** | **1,367** | **1,810** |
| **VMMC among males 15 years or older** | **9,673** | **22,006** |
| **DREAMS** *(AGYW completing at least the primary package)* | **1,724** *(43.7% of total AGYW reached)* | **n/a** |
| **Cervical Cancer** | **15,191** | **32,396** |
| **TB Preventive Therapy** | **n/a** | **72,305** |

***** *Note that these totals do not include centrally supported ARV procurement by Global Health Supply Chain-Procurement Supply Management (GHSC-PSM) (Chemonics, USAID).*

**Table 5. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget**

| OU/Agency | Sum of Approved COP 2018 Planning Level | Sum of Total FY 2019 Outlays | Sum of Over/Under Outlays |
|---|---|---|---|
| **OU** | **$70,239,250** | **$56,715,679** | **$13,523,571** |
| DOD | $1,745,014 | $531,907 | $1,213,107 |
| HHS/CDC | $28,772,639 | $24,485,673 | $4,286,966 |
| HHS/HRSA | $6,219,204 | $5,309,869 | $909,335 |
| PC | $3,458,127 | $2,165,396 | $1,292,731 |
| State | $241,263 | $215,000 | $26,263 |
| State/AF | $985,060 | $226,002 | $759,058 |
| USAID | $28,817,943 | $23,781,831 | $5,036,112 |
| **Grand Total** | **$70,239,250** | **$56,715,679** | **$13,523,571** |

*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

**Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget**

| Mech ID | Prime Partner | Funding Agency | COP 2018/FY 2019 Budget (New funding + Pipeline + Central) | Actual FY 2019 Outlays ($) | Over/Under FY 2019 Outlays (Actual $ - Total COP 2018 Budget $) |
|---|---|---|---|---|---|
| 17544 | Jhpiego | DOD | $0 | $453,788 | ($453,788) |
| 70004 | Association of Public Health Laboratories | HHS/CDC | $30,000 | $36,091 | ($6,091) |
| 17846 | Jhpiego | HHS/CDC | $200,000 | $436,157 | ($236,157) |
| 9915 | American Society for Microbiology | HHS/CDC | $100,000 | $293,417 | ($193,417) |
| 10313 | University of Pennsylvania | HHS/CDC | $0 | $525,674 | ($525,674) |
| 14790 | U.S. Department of State | State/AF | $110,060 | $120,958 | ($10,898) |
| 18685 | Chemonics International | USAID | $850,000 | $1,018,503 | ($168,503) |
| 17863 | John Snow, Inc. | USAID | $5,000,000 | $5,991,675 | ($991,675) |
| 17322 | University of North Carolina at Chapel Hill, Carolina Population Center | USAID | $329,978 | $410,378 | ($80,400) |
| 17321 | Catholic Relief Services | USAID | $0 | $141,300 | ($141,300) |
| 16714 | Abt Associates | USAID | $0 | $217,353 | ($217,353) |

*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

**Table 7. COP 2018 | FY 2019 Results and Expenditures**

| Agency | Indicator | FY 2019 Target | FY 2019 Result | % Achievement | Program Classification | FY 2019 Expenditure | % Service Delivery |
|---|---|---|---|---|---|---|---|
| HHS/CDC | HTS_TST | 24,011 | **49,920** | 207.9% | HTS Program Area | $780,938 | 100% |
| | HTS_TST_POS | 1,765 | **1,474** | 83.5% | | | |
| | TX_NEW | 35,421 | **8,957** | 25.3% | C&T Program Area | $6,476,107 | 74% |
| | TX_CURR | 197,744 | **154,557** | 78.2% | | | |
| | VMMC_CIRC | 21,001 | **16,461** | 78.4% | VMMC Subprogram of PREV | $2,957,344 | 100% |
| | OVC_SERV | n/a | **n/a** | n/a | OVC Major Beneficiary | n/a | n/a |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HHS/ HRSA | HTS_TST | 319,288 | 193,227 | 60.5% | HTS Program Area | $3,191,899 | 43% |
| | HTS_TST_POS | 23,833 | 11,333 | 47.6% | | | |
| | TX_NEW | n/a | n/a | n/a | C&T Program Area | $453,714 | 80% |
| | TX_CURR | n/a | n/a | n/a | | | |
| | VMMC_CIRC | n/a | n/a | n/a | VMMC Subprogram of PREV | n/a | n/a |
| | OVC_SERV | n/a | n/a | n/a | OVC Major Beneficiary | n/a | n/a |
| DOD | HTS_TST | 11,300 | 6,304 | 55.8% | HTS Program Area | $48,974 | 100% |
| | HTS_TST_POS | 247 | 140 | 56.7% | | | |
| | TX_NEW | n/a | n/a | n/a | C&T Program Area | $65,772 | 0% |
| | TX_CURR | n/a | n/a | n/a | | | |
| | VMMC_CIRC | 4,610 | 5,300 | 87.0% | VMMC Subprogram of PREV | $566,389 | 100% |
| | OVC_SERV | n/a | n/a | n/a | OVC Major Beneficiary | n/a | n/a |
| Peace Corps | HTS_TST | n/a | n/a | n/a | HTS Program Area | n/a | n/a |
| | HTS_TST_POS | n/a | n/a | n/a | | | |
| | TX_NEW | n/a | n/a | n/a | C&T Program Area | n/a | n/a |
| | TX_CURR | n/a | n/a | n/a | | | |
| | VMMC_CIRC | n/a | n/a | n/a | VMMC Subprogram of PREV | n/a | n/a |
| | OVC_SERV | 899 | 472 | 52.5% | OVC Major Beneficiary | $13,548 | 100% |
| USAID | HTS_TST | 168,257 | 44,067 | 26.2% | HTS Program Area | $1,914,903 | 84% |
| | HTS_TST_POS | 10,858 | 1,636 | 15.1% | | | |
| | TX_NEW | 3,747 | 6,304 | 168.2% | C&T Program Area | $10,066,271 | 72% |
| | TX_CURR | 1,072 | 63,713 | 5934.4% | | | |
| | VMMC_CIRC | n/a | n/a | n/a | VMMC Subprogram of PREV | n/a | n/a |
| | OVC_SERV | 15,484 | 14,066 | 90.8% | OVC Major Beneficiary | $1,409,277 | 90% |
| | | | | | **Above Site Programs** | $6,262,270 | |

| | | |
|---|---|---|
| | **Program Management** | $13,110,475 |

* *Note that the testing and treatment targets above reflect those currently in DATIM. During the COP 2019 approval process, testing and treatment targets were revised to reflect the "reboot" process, but were not updated in DATIM. Therefore the revised targets were not divided by agency.*

*The COP 2019 planning level letter, which shows the revised OU-level targets, is available at: https://www.state.gov/wp- content/uploads/2019/08/Botswana.pdf*

**COP 2018 | FY 2019 Analysis of Performance**

Case-Finding (active case finding was de-emphasized in reboot and community testing was stopped).

- PEPFAR Botswana should evaluate the diagnosis and testing policy across sites, in particular for TB and PMTCT, to ensure that partners are in line with WHO guidance.
- The COP 2018 distribution of HTS_TST_POS across modalities is not consistent with a strong, targeted, case-finding strategy characteristic of Botswana's stage in epidemic control. For example, other PITC contributed to 38% of HTS_TST_POS, while index testing (facility and community combined) contributed 16%. Testing will need to be transformed into case finding and facility and community collaboration is likely to be core to effective implementation of active partner notification strategies.
- During COP 2018 index testing implementation over the four quarters, elicitation acceptance rate ranged from 71% to 100%, contacts elicited per index case ranged from 1.0 to 2.1, and percent positivity ranged from 11% to 18%. The team should scale index testing with fidelity to ensure consistency and improved performance.
- University of Washington I-TECH (HHS/HRSA) is the main testing partner and shows 96% of the budget expended. HTS_TST_POS achievement was 11,333 against an original target of 23,833. Moving forward, the testing program will need to use funding more efficiently, focusing on high-yield modalities such as index testing and on known gaps and gaps as identified/affirmed by the BAIS.

Care and Treatment

- Overall OU performance of linkage during the reboot was promising, improving from 78% in FY 2019 mid-Q2 to 91% at the end of FY 2019 Q4, with increasingly improved linkage expected through FY 2020 as non-citizens are now able to access ART. PEPFAR Botswana should continue to work closely with the GOB to ensure same-day or rapid (<7 days) initiation of ART for all eligible clients, including non-citizens.
- Quarter-by-quarter gains and losses show challenges with retaining men and AGYW, particularly in Gaborone. Linkage and retention of treatment should be a key focus of COP 2020, particularly among these populations.
- Differentiated service delivery approaches and multi-month dispensing showed promise for improved retention and should be scaled.

Viral Load

- Overall OU viral load coverage and suppression have improved (96% and 98%, respectively). PEPFAR Botswana should improve the use of data to quickly identify sites

experiencing issues with viral load coverage and suppression for rapid response.

Cervical Cancer

- Though the target was not achieved, results from the cervical cancer program are promising, with a result of 15,191 or CXCA_SCRN_N against a target of 25,000. The team should ensure that cervical cancer screening is reaching all women living with HIV.

VMMC

- Overall OU performance of VMMC_CIRC was 21,010 against a target of 26,301. In COP 2018, 54% of VMMC results came from school-age children below the age of 15. Per COP 2020 technical guidance, PEPFAR Botswana should conduct VMMC only for males 15 and older, with a few caveats that must include full informed content. PEPFAR Botswana should update and adapt its VMMC strategy to better reach men ages 15-49.

OVC

- PEPFAR Botswana should ensure that OVC guidelines are followed with fidelity, including reporting for OVC_SERV per MER 2.4 guidelines, and at least 90% of children and adolescents on ART with PEPFAR support in OVC SNUs should be offered the opportunity to enroll in the comprehensive OVC program.

DREAMS

- COP 2018 results for DREAMS raised concerns regarding the number of AGYW, particularly young women ages 20-24 who did not complete the DREAMS primary package and the small scale of the program relative to other countries. In COP 2020, DREAMS is being expanded and Botswana is receiving an increase in new funding to expand into new districts and scale up PrEP. PEPFAR Botswana must ensure DREAMS is implemented in all priority, high prevalence districts with fidelity and address the challenges that have kept AGYW from completing the primary package to date.

Key Populations

- FHI360 Linkages (USAID) is the main key population partner in Botswana. 94% of the budget was expended. Linkages performed well against targets, including 107% against HTS_TST_POS and 97% against TX_NEW. However, the testing yield for MSM was 7.7% and for FSW was 12.4%, and the scale of the program remains relatively small compared to the budget. As EpiC begins implementation in COP 2019, PEPFAR Botswana should closely monitor progress and results, including whether partners are in the right networks, key population testing yields, and linkage to PrEP for all those testing HIV-negative.

## SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

**Table 8. COP 2020 (FY 2021) Minimum Program Requirements**

| | Minimum Program Requirement | Status | Outstanding Issues Hindering Implementation |
|---|---|---|---|
| **Care and Treatment** | 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1] | Adopted.<br>PEPFAR Botswana should now ensure – nationwide at the site level – that same-day or rapid (<7 days) initiation of ART is 100% available for all eligible clients, including non-citizens. | • Implementation and monitoring limited to facilities directly. supported by PEPFAR<br>• Insufficient client-centered service delivery. |
| | 2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2] | Adopted.<br>PEPFAR Botswana should complete the transition to TLD. | • Supply chain management and forecasting capacity<br>• Data availability |



[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

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|---|---|---|---|
| | 3. Adoption and implementation of differentiated service delivery models, including six-month multi- month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3] | Adopted, partially implemented.<br>PEPFAR Botswana should continue to expand DSD approaches in all sites with a client-centered approach and a focus on men and adolescents.<br>PEPFAR Botswana should continue to work with the GOB to increase the number of patients on three-month MMD and work on policy to get six-month MMD for stable patients. | • Implementation and monitoring limited to facilities directly supported by PEPFAR<br>• Persistently low ART coverage in men and youth |
| | 4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP 2020, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4] | Adopted, partially implemented.<br>PEPFAR Botswana should continue to work with the GOB and provide technical assistance support to ensure that TPT is fully integrated into clinical services and expanded to include all those eligible, including children. | • Implementation and monitoring limited to facilities directly supported by PEPFAR<br>• Insufficient client-centered service delivery. |
| | 5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, | Adopted, partially implemented.<br>PEPFAR Botswana has not yet conducted a full diagnostic network optimization activity. COP 2020 should include a plan on how to conduct this.<br>EID testing at 2 months should also be improved. | • Persistently high number of new HIV diagnoses presenting with late stage disease<br>• Insufficient client-centered service delivery. |



[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

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|---|---|---|---|
| | sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. | PEPFAR Botswana should work closely with the GOB to ensure that all implementers follow the WHO viral load algorithm for testing and cut off for viral suppression. | |
| **Case Finding** | 6. Scale up of index testing and self- testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5] | Adopted, partially implemented.<br>Now that the policies are in place, the team should work to implement index testing with fidelity. Index testing and active case finding for the diverse range of clients in Botswana may require the development of new capacities and networks. | • Current HRH and lay cadres may not be well suited for index testing work |
| **Prevention and OVC** | 7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of | Adopted, partially implemented.<br>The team should take a more client centered active approach to assessing risk and counselling HIV-negative clients on PrEP. | • Implementation and monitoring limited to facilities directly supported by PEPFAR<br>• Insufficient client-centered service delivery. |



[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

| | | | |
|---|---|---|---|
| | index cases, key populations and adult men engaged in high-risk sex practices)[6] | | |
| | 8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. | Adopted, partially implemented. OVC services must be more focused on caring for vulnerable children and families dealing with HIV and preventing HIV infections in at risk children and families. | • Scale and alignment in high prevalence districts |
| **Policy & Public Health Systems** | 9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and | Adopted | • Insufficient client-centered service delivery. |



6 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

| | | | |
|---|---|---|---|
| | related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7] | | |
| | 10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8] | Adopted.<br>As a strong user of the SIMS tools, the team should now look to tailor this and/or other CQI practices to the client, facility, and service delivery context. | • Implementation and monitoring limited to facilities directly supported by PEPFAR |
| | 11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV | Adopted. | • Legacy communication on timing for ART initiation<br>• Integration of results and data from of the Violence Against Children Survey (VACS) into programs |



[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

| | | | |
|---|---|---|---|
| | treatment and prevention. | | |
| | 12. Clear evidence of agency progress toward local, indigenous partner prime funding. | Agencies should work to ensure local capacity is leveraged whenever possible. | n/a |
| | 13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. | The GOB funds the majority of the national HIV response, which now includes non-citizens | n/a |
| | 14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | Adopted.<br>Data systems, now updated to collect TX_ML, should be actively leveraged as a tool to reduce morbidity and mortality. | n/a |
| | 15. Scale-up of case- based surveillance and unique identifiers for patients across all sites. | Adopted, partially implemented.<br>The case management system should be strengthened from a database to a tool/dashboard for situational awareness about a specific client's needs and epidemic control generally. | • Lack of central interoperable system<br>• Number, distribution, and diversity of ART sites |

In addition to meeting the minimum requirements outlined above, it is expected that Botswana will:

**Table 9. COP 2020 (FY 2021) Botswana Technical Directives**

| **Patient and Family-Centered Approach** |
|---|
| Overall COP 2020 guidance focuses on ensuring a patient and family-centered approach to improve linkage and retention. PEPFAR Botswana should:<br>• Work as an interagency team, and with the GOB and implementing partners, to improve the integration of client services and of community and facility approaches, with a focus on reaching clients where they are and reducing loss to follow-up.<br>• Continue to implement the community component using GOB community health workers to track and trace patients, improve retention, and reduce loss to follow-up.<br>• Continue to support GOB facility-based community care programs, especially where donor support is not available. |
| **Data Use and Data Quality** |
| Data collection, use, and analysis and improved data quality are essential for better understanding of the HIV epidemic and reaching epidemic control in Botswana. PEPFAR Botswana should:<br>• Work closely with the GOB on completion of the BIAS V, and be prepared to adapt and/or re-align the program as needed once data is available.<br>• Work closely with the GOB to ensure quality data is collected through improvement of electronic medical records, including ongoing work on PIMS interoperability with IPMS.<br>• Consistently and continuously use and analyze data with the aim of program improvement. Triangulate available data, including (but not limited to) the GOB-led MPR monitoring tools, MER results, custom community program indicators, SIMS results, site mapping, and other available survey and surveillance results. |
| **Case Finding** |
| PEPFAR Botswana should implement a case finding strategy consistent with its high level of epidemiological control, focusing on men and adolescents, and maintain and scale reboot activities that have proven successful at improving testing performance. This includes:<br>• Scale-up and optimization index testing<br>• Strengthening of facility and community collaboration to ensure effective implementation of active partner notification<br>• Scale-up and optimization of self-testing to enhance active partner notification<br>• Introduction of recency testing to guide case finding<br>• Testing all children of HIV positive mothers. |
| **Care and Treatment** |
| PEPFAR Botswana should focus on linkage and retention on treatment, especially sites and age/sex groups with poorer linkage and retention results, particularly for men and adolescents. Botswana should scale up linkage to treatment and retention activities that have shown impact during the reboot, and continue to explore male-friendly service delivery models. |

| **PMTCT** |
| --- |
| PEPFAR Botswana should work closely with the GOB to strengthen viral load coverage and reporting for pregnant and breastfeeding women, and improve early infant diagnosis coverage at two months. |
| **Cervical Cancer** |
| PEFAR Botswana should work closely with community systems to enhance cervical cancer prevention awareness and demand creation among women living with HIV. The team should ensure that cervical cancer screening is reaching all women living with HIV, and as possible expand to more high-volume ART sites and SNUs to reach more women living with HIV. Thermal ablation should be considered as the primary treatment modality. |
| **Supply Chain and Commodities** |
| PEPFAR Botswana should work closely with the GOB to:<br>• Expand and accelerate the use of decentralized distribution models of ARV to improve patient retention and adherence to ART.<br>• Support host government ownership of commodity procurement and supply chain by strengthening procurement and contract management systems and advancing pooled procurement approaches to achieve cost savings.<br>• Leverage the private sector in supply chain implementation to bring efficiencies and increased value in the supply chain system. |

**COP 2020 Technical Priorities**

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Botswana must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)
Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)
TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP 2020; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS
DREAMS is receiving an increase in new funding which should be used for the following:

- **Interagency** expansion into new districts: The following 6 districts should receive new DREAMS funds for COP 2020. These districts have very high incidence (1-1.36%), over 10,000 PLHIV, but have no DREAMS or Global Fund AGYW presence.

| Country | DREAMS SNU | UNAIDS F15-24 Incidence Estimate | UNAIDS Incidence Classification | PLHIV (COP19 DataPack) |
|---|---|---|---|---|
| Botswana | Bobirwa District | 1.36 | Very high | 18,667 |
| Botswana | Francistown District | 1.30 | Very high | 25,378 |
| Botswana | Palapye District | 1.10 | Very high | 11,899 |
| Botswana | Boteti District | 1.06 | Very high | 13,111 |
| Botswana | Selibe Phikwe District | 1.06 | Very high | 12,159 |
| Botswana | Southern District | 1.00 | Very high | 14,585 |

  - Note: The geographic expansion mentioned here is limited to NEW DREAMS funds. Any expansion within the existing DREAMS envelope is subject to the criteria laid out in COP 2020 guidance (i.e., must have reached saturation, must have shown progress via WAD modeling data, or some other data).
- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Botswana must present a strategy and a timeline at the COP meeting for the following:
  - Hire a dedicated DREAMS Coordinator (100% LOE)
  - Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
  - Implement approved, evidence-based curricula in line with the current DREAMS Guidance
  - Ensure a fully operable layering database with unique IDs across IPs and SNUs
  - Ensure a full geographic footprint in all districts

- Address challenges and ensure DREAMS implementation in all districts with fidelity

In addition, DREAMS Botswana should focus on the following:

- Layering: Ensure that each AGYW in DREAMS receives a layered package of services. Q4 AGYW_PREV data show that 26-96% of AGYW in DREAMS have not completed the full primary package of services, with the largest challenges in the 20-24 year old age band.
- Reach and enroll more AGYW. The number of AGYW reached in Botswana is very low compared to other DREAMS countries with similar budgets.
- Violence Against Children Survey: The Botswana VACS Report was released in December. Findings should be used to inform areas of focus and targeted interventions throughout COP planning.

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre- cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV

program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

**COP 2020 Stakeholder Engagement** (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2020 remains a requirement for all PEPFAR programs, and as such the COP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2020 development and finalization process. As in COP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2020 Guidance for a full list of requirements and engagement timelines.

**APPENDIX 1: Detailed Budgetary Requirements**

**Table 10: COP 2020 New Funding Detailed Initiative Controls**

| | COP 2020 Planning Level | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY20 | | | FY19 | | | FY17 | | | COP 20 Total |
| | GHP-State | GHP-USAID | GAP | GHP-State | GHP-USAID | GAP | GHP-State | GHP-USAID | GAP | |
| Total New Funding | **$ 56,112,301** | **$ -** | **$ 2,196,250** | **$ 5,000,000** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 63,308,551** |
| Core Program | $ 54,512,301 | $ - | $ 2,196,250 | $ 5,000,000 | | | | | | **$ 61,708,551** |
| COP19 Performance | $ - | | | | | | | | | **$ -** |
| HKID Requirement ++ | $ 1,600,000 | | | | | | | | | **$ 1,600,000** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |

*++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia*

*Care and Treatment: If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.*

*Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.*

*HKID Requirement: Botswana's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP 2020 HKID requirement is derived based upon the approved COP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.*

*Gender Based Violence (GBV): Botswana's COP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total* ***new FY 2020*** *funding programmed to the GBV cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 GBV earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: Botswana's COP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total* ***new FY 2020 funding*** *programmed to the water cross-cutting code. Your COP 2020 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

*Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal* ***by agency*** *by the end of FY 2020 and must meet 40% by FY 2019. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 2020 as appropriate through their COP 2019 submission.*

**COP 2020 Applied Pipeline (**See Section 9.1.2 Applied Pipeline of COP Guidance)

*All agencies in Botswana should hold a 3 month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.*